FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028787

Facility Name: Taylorville Care Center

Address: 600 South Houston (Number) Taylorville (City) 62568 (Zip Code)

County: Christian

Telephone Number: (217) 824-9636 **Fax #** (217) 824-2472

IDPA ID Number: 37-11060662

Date of Initial License for Current Owners: 08/01/1984

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) Compilation Report Attached (Date)

(Print Name and Title) J. Terry Dooling, Partner

(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Previe

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,868	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,878	1,430	2,397	6,705	8
9	SNF/PED					9
10	ICF	14,456	12,066		26,522	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,334	13,496	2,397	33,227	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.64%

D. How many bed-hold days during this year were paid by Public Aid?
99 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2397

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,584	9,759	5,883	127,226	492	127,718	0	127,718			1
2	Food Purchase		141,620		141,620		141,620	(11,766)	129,854			2
3	Housekeeping	58,274	12,981		71,255		71,255	1,525	72,780			3
4	Laundry	44,914	12,907		57,821		57,821	0	57,821			4
5	Heat and Other Utilities			62,165	62,165		62,165	(230)	61,935			5
6	Maintenance	50,960	89,036	939	140,935	2,285	143,220	21,767	164,987			6
7	Other (specify):* Sanitation			6,193	6,193		6,193	0	6,193			7
8	TOTAL General Services	265,732	266,303	75,180	607,215	2,777	609,992	11,296	621,288			8
	B. Health Care and Programs											
9	Medical Director			8,800	8,800		8,800	0	8,800			9
10	Nursing and Medical Records	1,017,694	64,328	17,724	1,099,746		1,099,746	0	1,099,746			10
10a	Therapy		7,578	115,388	122,966		122,966	0	122,966			10a
11	Activities	23,472	2,988	4,331	30,791		30,791	0	30,791			11
12	Social Services	27,579			27,579		27,579	0	27,579			12
13	Nurse Aide Training			492	492	(492)		0				13
14	Program Transportation		1,618		1,618		1,618	0	1,618			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,068,745	76,512	146,735	1,291,992	(492)	1,291,500		1,291,500			16
	C. General Administration											
17	Administrative	57,694	9,641	220,000	287,335	(2,704)	284,631	(139,025)	145,606			17
18	Directors Fees							0				18
19	Professional Services			26,601	26,601		26,601	(2,512)	24,089			19
20	Dues, Fees, Subscriptions & Promotions			9,139	9,139	2,004	11,143	(2,747)	8,396			20
21	Clerical & General Office Expenses	43,148	14,174	17,559	74,881		74,881	29,288	104,169			21
22	Employee Benefits & Payroll Taxes			185,682	185,682	(1,585)	184,097	13,653	197,750			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			1,830	1,830		1,830	59	1,889			24
25	Other Admin. Staff Transportation							1,448	1,448			25
26	Insurance-Prop.Liab.Malpractice			3,845	3,845		3,845	12,025	15,870			26
27	Other (specify):*							0				27
28	TOTAL General Administration	100,842	23,815	464,656	589,313	(2,285)	587,028	(87,811)	499,217			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,435,319	366,630	686,571	2,488,520		2,488,520	(76,515)	2,412,005			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,319	24,319		24,319	69,879	94,198			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes							35,158	35,158			33
34	Rent-Facility & Grounds			277,800	277,800		277,800	(277,800)				34
35	Rent-Equipment & Vehicles			719	719		719	0	719			35
36	Other (specify):*							0				36
37	TOTAL Ownership			302,838	302,838		302,838	(172,763)	130,075			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		50,000	1,205	51,205		51,205	(414)	50,791			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			53,802	53,802		53,802	0	53,802			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		50,000	55,007	105,007		105,007	(414)	104,593			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,435,319	416,630	1,044,416	2,896,365	0	2,896,365	(249,692)	2,646,673			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,053)	2		4
5	Telephone, TV & Radio in Resident Rooms	(890)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,527)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,225)	17		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,980)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,339)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,185)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(553)	21		28
29	Other-Attach Schedule	(7,444)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,196)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(219,496)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (219,496)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (249,692)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **Taylorville Care Center**

ID# **0028787**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

Print Other Adjustment

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(11,766)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	(1,053)	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(890)	5	**Line 5**	(890)
6	**Rented Facility Space**	0	0	**Line 6**	784
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	(11,872)
9	**Non-Straightline Depreciation**	0	0	**Line 9**	0
10	**Interest and Other Investment Income**	0	0	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(1,527)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	0
18	**Fines and Penalties**	(4,225)	17	**Line 17**	(4,536)
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	0	0	**Line 19**	(5,980)
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	(2,944)
22	**Special Legal Fees & Legal Retainers**	(5,980)	19	**Line 21**	(7,738)
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	0	0	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(1,339)	20	**Line 24**	0
26	**Income & IL Personal Property ReplacementTaxes**	(7,185)	21	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	(553)	21	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(21,198)
30	**Donated Goods**	0	0	**Line 29**	(33,070)
31	**Amortization Expense**	0	0	**Line 30**	3,288
32	Pharmacy Refund	(414)	39	**Line 31**	0
33	Promotional Advertising	(115)	17	**Line 32**	0
34	Chamber of Commerce Dues	(196)	17	**Line 33**	0
35	Vending Machine Cost	(9,186)	2	**Line 34**	0
36	2001 IHCA Dues	(4,441)	20	**Line 35**	0
37	2000 IHCA Dues	2,836	20	**Line 36**	0
38	Depr. on Items Req'd to be Capitalized for Cost Reporting	3,288	30	**Line 37**	3,288
39	Deferred Maintenance	784	6	**Line 38**	0
40				**Line 39**	(414)
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	(414)
46				**Line 45**	(30,196)
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,766)	0	0	0	0	0	0	0	0	0	0	(11,766)	2
3	Housekeeping	0	1,525	0	0	0	0	0	0	0	0	0	1,525	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(890)	660	0	0	0	0	0	0	0	0	0	(230)	5
6	Maintenance	784	20,983	0	0	0	0	0	0	0	0	0	21,767	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,872)	23,168	0	0	0	0	0	0	0	0	0	11,296	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(4,536)	(134,489)	0	0	0	0	0	0	0	0	0	(139,025)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,980)	3,468	0	0	0	0	0	0	0	0	0	(2,512)	19
20	Fees, Subscriptions & Promotions	(2,944)	197	0	0	0	0	0	0	0	0	0	(2,747)	20
21	Clerical & General Office Expenses	(7,738)	37,026	0	0	0	0	0	0	0	0	0	29,288	21
22	Employee Benefits & Payroll Taxes	0	13,653	0	0	0	0	0	0	0	0	0	13,653	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	59	0	0	0	0	0	0	0	0	0	59	24
25	Other Admin. Staff Transportation	0	1,448	0	0	0	0	0	0	0	0	0	1,448	25
26	Insurance-Prop.Liab.Malpractice	0	1,179	10,846	0	0	0	0	0	0	0	0	12,025	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,198)	(77,459)	10,846	0	0	0	0	0	0	0	0	(87,811)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,070)	(54,291)	10,846	0	0	0	0	0	0	0	0	(76,515)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	3,288	4,191	62,400	0	0	0	0	0	0	0	0	69,879	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	643	34,515	0	0	0	0	0	0	0	0	35,158	33
34	Rent-Facility & Grounds	0	0	(277,800)	0	0	0	0	0	0	0	0	(277,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,288	4,834	(180,885)	0	0	0	0	0	0	0	0	(172,763)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(414)	0	0	0	0	0	0	0	0	0	0	(414)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(414)	0	0	0	0	0	0	0	0	0	0	(414)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(30,196)	(49,457)	(170,039)	0	0	0	0	0	0	0	0	(249,692)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: Tuscola Hlth Care Center — # 0020787 — Report Period Beginning: 01/01/2000 — Ending: 12/31/2000

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00%	K & G Inc., d/b/a Mt. Vernon	Mt. Vernon	King Management	Nashville	Home office
		Countryside Manor		Congenic		
Jerry & Marilyn King	100.00%	Aviston Nursing Center, Inc. d/b/a	Aviston			
		Countryside Manor				
Jerry & Marilyn King	100.00%	King Management, Inc. d/b/a	Nokomis			
		Nokomis Golden Manor				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization — Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 6)		Sum_6
1	V	2 See Schedule VIII		King Management	100.00%	$ 1,525	$ 1,525	1	1525
2	V	5 See Schedule VIII		King Management	100.00%	560	560	2	560
3	V	6 See Schedule VIII		King Management	100.00%	20,983	20,983	3	20983
4	V	15 See Schedule VIII	129,480	King Management	100.00%	15,511	(124,489)	4	-114489
5	V	19 See Schedule VIII		King Management	100.00%	3,468	3,468	5	3468
6	V	20 See Schedule VIII		King Management	100.00%	197	197	6	197
7	V	21 See Schedule VIII		King Management	100.00%	37,926	37,926	7	37926
8	V	23 See Schedule VIII		King Management	100.00%	12,653	12,653	8	13653
9	V	24 See Schedule VIII		King Management	100.00%	59	59	9	59
10	V	25 See Schedule VIII		King Management	100.00%	1,448	1,448	10	1448
11	V	26 See Schedule VIII		King Management	100.00%	1,179	1,179	11	1179
12	V	29 See Schedule VIII		King Management	100.00%	4,191	4,191	12	4191
13	V	30 See Schedule VIII		King Management	100.00%	643	643	13	643
14	Total		$ 226,000			$ 176,543	$ (49,457)	14	

* Total must agree with the amount recorded on line 30 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPOR

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6E, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6E, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6E, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	Rent - Facility & Grounds	$ 277,800	Jerry & Marilyn King	100.00%	$	$ (277,800)	15	-277800
16	V	26	Insurance		Jerry & Marilyn King	100.00%	10,846	10,846	16	10846
17	V	30	Depreciation		Jerry & Marilyn King	100.00%	62,400	62,400	17	62400
18	V	33	Real Estate Taxes		Jerry & Marilyn King	100.00%	34,515	34,515	18	34515
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 277,800			$ 107,761	$ * (170,039)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00%	128,823	16	26.13%	Salary	$ 45,580	17,8	1
2	Denise King	Regional Director	Administrative	0.00%	100,840	13	26.13%	Salary	35,679	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00%	54,714	10	26.13%	Salary	19,359	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00%	92,288	0	0.00%	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00%	2,496	0	0.00%	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00%	4,432	1	26.13%	Salary	1,568	21,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 102,186		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: King Management Company
Street Address: 935 South Mill Street
City / State / Zip Code: Nashville, Illinois 62263
Phone Number: (618) 327-3064
Fax Number: (618) 327-3083

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	127,091	4	$ 5,835	$ 5,835	33,215	$ 1,525	1
2	5	Utilities	Patient Days	127,091	4	2,526		33,215	660	2
3	6	Maintenance	Patient Days	127,091	4	80,286	74,072	33,215	20,983	3
4	17	Administrative	Patient Days	127,091	4	327,191	316,921	33,215	85,511	4
5	19	Professional Fees	Patient Days	127,091	4	13,268		33,215	3,468	5
6	20	Fees, Subs & Promotions	Patient Days	127,091	4	755		33,215	197	6
7	21	Clerical & Gen. Office Expense	Patient Days	127,091	4	141,674	113,988	33,215	37,026	7
8	22	Employee Benefits	Patient Days	127,091	4	52,239		33,215	13,653	8
9	24	Travel & Seminar	Patient Days	127,091	4	225		33,215	59	9
10	25	Other Admin. Staff Transport.	Patient Days	127,091	4	5,541		33,215	1,448	10
11	26	Insurance	Patient Days	127,091	4	4,510		33,215	1,179	11
12	30	Depreciation - Vehicles	Patient Days	127,091	4	6,622		33,215	1,731	12
13	30	Depreciation - Vehicles	Direct Cost	N/A	1	3,875		N/A		13
14	30	Depreciation - Other	Patient Days	127,091	4	9,414		33,215	2,460	14
15	30	Depreciation - Copier	Direct Cost	N/A	1	359		N/A		15
16	35	Property Taxes	Patient Days	127,091	4	2,460		33,215	643	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 656,780	$ 510,816		$ 170,543	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Schedule Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	33,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	33,015	2
3. Under or (over) accrual (line 2 minus line 1).	$	(85)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	34,515	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	33,022	8
	1996	32,736	9
	1997	33,305	10
	1998	33,080	11
	1999	33,015	12

Line 2: Real Estate Taxes paid are for the 1999 tax year

Line 4: Accrual is based on 1999 taxes paid

Line 7: $34,515 Real Estate Tax

643 Home Office Allocatior

$35,158 Total Real Estate Ta

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb. Sprinkle Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Taylorville Estates is a 39 unit (27,945 square foot) retirement center which is located on the property adjacent to Taylorville Care Center.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	98 Bed Nursing Home	186,200	1984	$ 40,000	1
2	Home Office Land		1989	1,644	2
3	TOTALS	186,200		$ 41,644	3

SEE ACCOUNTANTS' COMPILATION REPORT

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1984	1974	$ 1,560,000	$	25	$ 62,400	$ 62,400	$ 1,029,817	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	80 Gallon Water Fixture			1985	1,581		10			1,581	9
10	Improvement to Building			1985	12,510	500	25	500		7,507	10
11	Improvement to Parking Lot			1986	1,184		10			1,184	11
12	New Light Fixtures			1987	997		10			997	12
13	Tile Floor			1987	5,941	142	10		(142)	5,941	13
14	Roof			1988	55,100		10			55,100	14
15	Addition to Alarm System			1988	5,610		10			5,610	15
16	Concrete Driveway			1989	2,729	182	15	182		2,123	16
17	Nurses Station			1991	4,809		15	321	321	3,099	17
18	Water Heater			1993	3,750	250	15	250		1,958	18
19	Air Conditioner			1993	2,800	280	10	280		2,076	19
20	New Offices			1993	1,500	38	40	38		263	20
21	4" Backflow Preventer			1994	3,966	159	25	159		1,110	21
22	Carpeting			1994	2,471	247	10	247		1,565	22
23	Circulating Pump on Water Heater			1994	2,450	175	14	175		1,094	23
24	Fence			1995	3,590	239	15	239		1,335	24
25	Water Heater			1995	1,602	107	15	107		633	25
26	Sprinkler Heads			1995	1,600	107	15	107		543	26
27	New Roof			1996	25,000	2,500	10	2,500		11,042	27
28	Water Softener			1996	5,908	492	12	492		2,132	28
29	Ceramic Tile			1997	5,167	517	10	517		2,025	29
30	Garage			1997	7,841	784	10	784		2,744	30
31	Rooftop A/C, Ducts & Gas Lines			1997	10,940	1,094	10	1,094		3,829	31
32	Beauty Shop Addition			1997	6,823	455	15	455		1,365	32
33	Carpet			1998	4,154	415	10	415		1,107	33
34	Windows			1998	5,681	568	10	568		1,420	34
35	Continued on Additional Page										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 9,251		$ 71,830	$ 62,579	$ 1,149,200	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Heating & A/C Units			1998	4,128	826	5	826		1,858	9
10	Air Conditioner Units			1999	25,051	2,505	10	2,505		3,967	10
11	Rear Parking Lot/Driveway			1999	2,995	299	10	299		375	11
12	Air Conditioner Units			2000	4,834	161	10	161		161	12
13											13
14	Home Office Parking Lot			1989	517		10			517	14
15	Home Office Building			1995	25,620		25	1,025	1,025	5,295	15
16	Home Office Interior Finishes Lower Level			1996	1,589		15	106	106	477	16
17	Home Office Carpet			1996	556		5	111	111	500	17
18	Home Office Cabinets			1996	879		20	44	44	198	18
19	Home Office Electrical			1996	304		15	20	20	91	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 3,791		$ 5,097	$ 1,306	$ 13,439	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 111,938	$ 10,291	$ 14,330	$ 4,039	5-10	$ 69,958	37
38	Current Year Purchases	12,830	986	1,210	224	5-10	1,210	38
39	Fully Depreciated Assets	221,646					221,646	39
40								40
41	TOTALS	$ 346,414	$ 11,277	$ 15,540	$ 4,263		$ 292,814	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Home Office Vehicle	1998 Ford F150 Truck	1997	$ 6,922	$	$ 1,731	$ 1,731	5	$ 5,480	42
43	Facility Business	1994 Chevy Van	1995	13,590				5	13,590	43
44	Home Office Vehicle	1996 Chrysler Concord	1995	6,455				5	6,455	44
45										45
46	TOTALS			$ 26,967	$	$ 1,731	$ 1,731		$ 25,525	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 24,319	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 94,198	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 69,879	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,480,978	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO
16. Rental Amount for movable equipment: $ 719 Description: Dishwasher
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

ONLY HIRED CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	2,651	$ 45,371	$	2,651	$ 45,371	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		849	23,351		849	23,351	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,413	46,666	7,578	2,413	54,244	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				50,000		50,000	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-Ray	39,3					1,205		1,205	13
14	TOTAL			$	5,913	$ 115,388	$ 58,783	5,913	$ 174,171	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 194,529	$	1
2	Cash-Patient Deposits	2,594		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	594,585		3
4	Supply Inventory (priced at cost)	5,003		4
5	Short-Term Investments	209,434		5
6	Prepaid Insurance	12,944		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,019,089	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	150,177		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	336,253		16
17	Accumulated Depreciation (book methods)	(348,896)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,165		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,165)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	13,206		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 150,740	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,169,829	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,913	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,594		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,816		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 198,861	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 198,861	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 970,968	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,169,829	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 654,987	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 654,987	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	720,981	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(405,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 315,981	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 970,968	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,180,101	1
2	Discounts and Allowances for all Levels	244,289	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,424,390	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	160,831	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 160,831	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,008	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,008	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellanous Income	14,800	28
28a	Diaper Charges	4,317	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,117	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,617,346	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 607,215	31
32	Health Care	1,291,992	32
33	General Administration	589,313	33
	B. Capital Expense		
34	Ownership	302,838	34
	C. Ancillary Expense		
35	Special Cost Centers	51,205	35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,896,365	40
41	**Income before Income Taxes (line 30 minus line 40)****	720,981	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 720,981	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,863	2,134	$ 43,563	$ 20.41	1
2	Assistant Director of Nursing	1,874	1,815	32,488	17.90	2
3	Registered Nurses	6,798	7,277	110,540	15.19	3
4	Licensed Practical Nurses	23,026	23,916	291,631	12.19	4
5	Nurse Aides & Orderlies	62,784	65,404	539,472	8.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,305	3,472	23,472	6.76	10
11	Social Service Workers	3,520	3,749	27,579	7.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,769	16,496	111,584	6.76	15
16	Dishwashers					16
17	Maintenance Workers	4,194	4,453	50,960	11.44	17
18	Housekeepers	8,636	9,343	58,274	6.24	18
19	Laundry	7,346	7,600	44,914	5.91	19
20	Administrator	1,942	2,198	57,694	26.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,907	4,211	43,148	10.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,964	152,068	$ 1,435,319 *	$ 9.44	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 5,883	1,3	35
36	Medical Director	Contract	8,800	9,3	36
37	Medical Records Consultant	9	621	10,3	37
38	Nurse Consultant	Contract		10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Contract	5,892	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	84	4,331	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	254	$ 25,527		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	690	11,211	10,3	52
53	TOTAL (lines 50 - 52)	690	$ 11,211		53

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margery Oblinger	Administrator	0.00%	$ 57,694
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,694

B. Administrative - Other

Description	Amount
Management Fees	$ 220,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 220,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	$ 11,115
Mathis, Marifan, Richter & Grandy	Legal	1,034
Holleb & Coff	Legal	350
Duane, Morris & Heckscher	Legal	8,065
Greensfelder, Hemker & Gale	Legal	6,037
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 26,601

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,700
Unemployment Compensation Insurance	30,850
FICA Taxes	108,046
Employee Health Insurance	8,387
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	1,962
Home Office Allocation	13,653
Employee Physicals	1,452
Employee Christmas Party	700
TOTAL (agree to Schedule V, line 22, col.8)	$ 197,750

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,359
Health Care Worker Background Check	
(Indicate # of checks performed 59)	710
Subscriptions	556
Other Dues & Licenses	538
IHCA Dues	2,836
Home Office Dues & Subscriptions	197
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,396

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,830
Home Office Allocation	59
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,889

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Interior Repainting	4/97	$ 7,058	3	$ 1,568	$ 2,353	$ 2,353	$ 784	$	$	$	$	$
2													
3													
4													
5													
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16													
17													
18													
19													
20	TOTALS		$ 7,058		$ 1,568	$ 2,353	$ 2,353	$ 784	$	$	$	$	$

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Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $2,836**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,972** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,802**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,053**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **52.77%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

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